STATE OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: July 19, 2022
[redacted]
AGENCY: Albany
FH #: 8477309M

In the Matter of the Appeal of

[redacted]

from a determination by the Albany County Department of Social Services

DECISION AFTER FAIR HEARING

JURISDICTION

Pursuant to Section 22 of the New York State Social Services Law (hereinafter Social Services Law) and Part 358 of Title 18 NYCRR, (hereinafter Regulations), a fair hearing was held on October 27, 2022, in Albany County, before an Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant

[redacted]

For the Social Services Agency

Brittany Hjalte, NYIA Representative/Quality Assurance Nurse (by telephone)

ISSUE

Was the Agency's determination to deny the Appellant's request for enrollment into a managed long term care (MLTC) plan based on the Appellant failing to meet the qualifying criteria, correct?

FINDINGS OF FACT

An opportunity to be heard having been afforded to all interested parties and evidence having been taken and due deliberation having been had, it is hereby found that:

1. The Appellant, age [redacted], is currently in receipt of Medical Assistance.

2. The Appellant lives alone and has no formal or informal support.
3. A request was made on the Appellant's behalf to enroll into Managed Long-Term Care (MLTC) to receive Personal Care Services for 120 days or more.

4. On June 14, 2022, a community health assessment (CHA) utilizing the Uniform Assessment System-New York (UAS-NY) was conducted of the Appellant in person by an Agency nurse evaluator.

5. The nurse evaluator indicated on the CHA report that the Appellant has been diagnosed with the following medical conditions: [redacted] (unspecified). The nurse evaluator further indicated the following:

- Consumer is a [redacted], English speaking, male that lives in a [redacted] floor of an apartment building for [redacted]. 1 bedroom. No steps into the home. And an elevator taken to the [redacted] floor. No others live in the home.
- Consumer reports increased need for assistance with ADL/IADL due to [redacted]. And [redacted]. Physical therapy rehab x5 times through [redacted] reports over the last 5 years. Consumer reports having a life alert necklace that was sent in the mail to him during COVID.

6. The nurse evaluator indicated on the CHA report that the Appellant requires assistance with Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) as follows:

Activity	Level of Assistance
Meal preparation—performance	Independent
Meal preparation—capacity	Independent
Ordinary housework—performance	Independent
Ordinary housework -capacity	Limited assistance
Managing finances—performance	Independent
Managing finance—capacity	Independent
Managing medications—performance	Independent
Managing medications—capacity	Independent
Phone use—performance	Independent
Phone use—capacity	Independent
Stairs—performance	Activity did not occur
Stairs—capacity	Maximal assistance
Shopping—performance	Limited assistance
Shopping—capacity	Limited assistance
Transportation—performance	Extensive assistance
Transportation—capacity	Extensive assistance
Bathing	Independent
Personal hygiene	Independent
Dressing upper body	Independent
Dressing lower body	Independent

Walking	Independent
Locomotion	Independent
Transfer toilet	Independent
Toilet use	Independent
Bed Mobility	Independent
Eating	Independent

7. In the Comments to Section F, Functional Status, of the CHA report, the nurse evaluator indicated the following:

- Consumer reports needing assistance with ADL/IADLs due to [redacted]. He reports receiving no assistance from anyone at this time. NA observed consumer to rise with great difficulty, using the chair arms and cane to rise. He ambulates with a slow, unsteady gait. He was able to turn around using wall for balance. Consumer reports all meals are prepared, plated and served without assist. He reports ability to cut meats and feed himself without assist. NA observed home to be clean, but untidy. Consumer reports he is unable to lift things around his home to move them out of the way due to pain and fatigue. He reports when anyone comes to visit, he will ask them to help with as much as possible while there. Consumer reports ability to access funds, and pay all bills without assist. He reports ability to open bottles, fill medication dispenser weekly, and take medications without assist or reminders. Consumer reports ability to make and receive calls without assist. He reports inability to ascend steps due to extreme pain and unstable gait. He reports not using steps anywhere. He will not go into a building that does not have an elevator. Consumer reports ability to shop using cart and cane. He reports asking for help from staff at store to lift heavier things into cart for him and then leaves in cart until someone can help lift out when home. He reports using [redacted] for all transport. He reports the staff will help him in and out of bus. Consumer reports ability to get into shower and bathe without assist. NA observed a walk in shower, and foot cleaner on floor of shower to wash his feet due to his ability to bend over. He reports all hygiene performed without assist. NA observed consumer to raise arms above head level with no facial grimacing or complaints or pain. Consumer reports ability to choose clothing and don upper and lower clothing without assist. He does report this takes a long time due to taking many breaks from fatigue and pain. He reports ability to lower and rise from toilet using grab bars and cane, but with difficulty. He reports ability to clean self without assist. Consumer reports ability to move in bed and rise from without assist. But he does reports difficult getting up daily due to pain and decreased mobility. Consumer reports leaving home daily the last 3 days. He reports going to medical appointment and to the store for needs.

8. The CHA report provides in Section I: Health Conditions, in part as follows:

- The Appellant had a fall thirty to ninety days prior to the report.
- The Appellant had unsteady gait.

- The Appellant has a moderate inability to complete normal daily activities- e.g., ADLs, IADLs, due to diminished energy. Therefore, normal day-to-day activities were unable to be finished.
- The Appellant had severe constant pain that was not adequately controlled.

9. The nurse evaluator determined that the Appellant's nursing facility level of care score (NFLOC) was [redacted] in one portion of the assessment. However, the nurse assessor subsequently noted in the assessment that the Appellant had a NFLOC score of [redacted].

10. In the "Sign/Finalize" section, the following was provided as "Comments for Next Assessment":

> Consumer is an alert, oriented and [redacted], [redacted] who lives alone in a clean and clutter free, [redacted] city apartment accessed by twelve stairs and a handrail; he has [redacted] and has difficulty with standing, bending and with activity and difficulty with maintaining his care and the care of his apartment and would benefit from assistance to help him with cleaning, laundry, shopping, bathing, and dressing and qualifies for MLTC of a 120 days or greater with an NFLOC score of [redacted].

11. The nurse evaluator then determined further in the "Sign/Finalize" section that regarding service needs, the Appellant did not have a need for 120 days continuous services.

12. On July 1, 2022, a Medical Practitioner completed and signed a Medical Review and Practitioner's Order Form.

13. By notice dated July 13, 2022, the Agency informed the Appellant that the Appellant's clinical exam showes that the Appellant does not qualify to enroll in an MLTC plan. The notice further states:

> You do not need any of the below for more than 120 days. To get long term service and supports in an MLTC plan, you must require one of these services for more than 120 days:
>
> - Nursing services in the home
> - Home health aide service
> - Private duty nursing
> - Personal care services in the home
> - Adult day health care
> - Consumer Directed Personal Assistance Services (CDPAS)
> - Therapies in the home (physical, occupational, respiratory and speech pathology).

In addition, your clinical exam shows your health condition is stable to get PCS and/or CDPAS at home."

14. On July 19, 2022, the Appellant requested this fair hearing.

APPLICABLE LAW

MLTC Policy 13.03 provides, in part, that a requirement of eligibility for enrollment in a Managed Long Term Care plan is for the consumer to demonstrate need for CBLTC Services for more than 120 days. These services are defined as: Nursing Services in the home, Home Health Care (which is further defined as traditional CHHA services such as therapies or home health aide service in the home), Personal Care Services in the home …, Adult Day Health Care, Private Duty Nursing; and … Consumer Directed Personal Assistance Services. Social Day Care … is no longer considered as a CBLTC service for purposes of determining plan eligibility. Social Day Care remains a benefit in the service package.

MLTC Policy 13.21 provides, in part, that the purpose of this policy is to further clarify the definition of community based long term care. Individuals who only require assistance with housekeeping tasks do not meet the intent of community based long term care services.

Office of Health Insurance Programs Administrative Directive 22 OHIP/ADM-01, entitled "New York Independent Assessor for Personal Care (PCS) and Consumer Directed Personal Assistance Services (CDPAS)," which was published on April 20, 2022, provides Local Departments of Social Services (LDSS) with information and guidance regarding changes in the initial assessment process for how Personal Care Services (PCS) and Consumer Directed Personal Care Services (CDPAS) are assessed for adults (18 and over) after May 16, 2022.

Pursuant to the ADM, the New York Independent Assessor (NYIA) will conduct all initial Community Health Assessments (CHA) in the Uniform Assessment System-New York (UAS-NY) for individuals seeking PCS and/or CDPAS under the Medicaid State Plan, delivered through the Local Department of Social Services (LDSS), or through Medicaid Managed Care Organizations (MMCOs). The CHA will also be used by NYIA to determine Managed Long Term Care (MLTC) Plan eligibility. This ADM should be read with 12 ADM 01 and 16 ADM 02 in mind, and where they differ, this ADM supersedes previous guidance.

22 OHIP/ADM-01 also provides that through a contract with MAXIMUS Health Services, Inc. (MAXIMUS) the NYIA has been created to conduct independent assessments, provide independent practitioner orders, and perform independent reviews of high needs cases for PCS and CDPAS. The NYIA will also take over the work currently done by the Conflict Free Evaluation and Enrollment Center (CFEEC) to assess individuals for MLTC plan eligibility.

22 OHIP/ADM-01 further provides that on or after May 16, 2022, anyone seeking PCS and/or CDPAS for the first time or seeking initial MLTC plan eligibility must be referred to the NYIA for their CHA and Clinical Appointment. Beginning May 16, 2022, the NYIA will conduct all initial assessments for adults (18 and over), including fee for service (FFS) Medicaid

recipients and MMC/HARP/SNP enrollees. The CHA and Clinical Appointment completed by the NYIA will assess for PCS and/or CDPAS service needs and, where applicable, MLTC plan eligibility. The LDSS (or MMCO) will no longer conduct a separate CHA to authorize these services.

18 NYCRR Section 505.14(b)(1) and the opening paragraph of section 505.28(d) provide an overview of the assessment process, which consists of an independent community health assessment (CHA), a clinical appointment which includes an independent medical examination and practitioner order (PO), an evaluation of the need and cost-effectiveness of services, the development of the plan of care, and, when required, an additional independent medical review for high needs cases. The paragraph further provides for how portions of the process may be conducted through telehealth modalities.

22 OHIP/ADM-01 provides that the NYIA will only conduct the initial assessment process for individuals with active Medicaid. If the NYIA Customer Service Representative (CSR) cannot verify the individual's Medicaid enrollment, or if the enrollment is not current, the CSR will refer the individual to the LDSS to apply for, or request an increase in, Medicaid to include coverage of community based long term care services before returning to the NYIA for the CHA and clinical appointment. The only exception to this rule will be individuals that the LDSS refers to the NYIA for assessment based on Immediate Need for services using the NYIA Expedited/Immediate Need Assessment Request Form.

In addition, 22 OHIP/ADM-01 provides that to be authorized for PCS and/or CDPAS, as well as other community based long term services and support (CBLTSS), individuals must have Medicaid with:

- coverage of all covered care and services or
- community coverage with community-based long-term care, or
- either of the above coverage types with a spenddown.

Pursuant to 22 OHIP/ADM-01, individuals who are authorized for Medicaid through the New York State of Health (NYSOH – New York's Health Insurance Exchange) must have their coverage transferred to the LDSS in order to receive these services through the LDSS or an MLTC plan. The NYIA CSR will verify the individual's Medicaid coverage and inform them if their coverage needs to be redetermined for eligibility to receive PCS and/or CDPAS. If the individual's Medicaid coverage needs to be redetermined, the CSR will refer the individual to their LDSS for further action to obtain a determination of eligibility for Medicaid coverage of PCS and/or CDPAS. The LDSS can assess the individual's Medicaid eligibility for appropriate coverage concurrently with NYIA's assessment process to reduce the time to service authorization once if the individual is determined to be financially eligible for Medicaid coverage of these services and, where applicable, MLTC enrollment.

18 NYCRR §505.14(b)(4)(i) states that "an individual's eligibility for medical assistance and services, including the individual's financial eligibility and eligibility for personal care services" must be established before services are authorized or reauthorized. Even in the case

where an individual seeks PCS and/or CDPAS based on an immediate need, services may not be authorized and commenced unless this coverage is in place.

Starting May 16, 2022, in accordance with 22 OHIP/ADM-01, the LDSS must refer individuals with active Medicaid eligibility who are seeking an initial assessment for PCS or CDPAS to NYIA. As stated above, the LDSS can assess the individual's Medicaid eligibility for appropriate coverage concurrently with NYIA's assessment process to reduce the time to service authorization once if the individual is determined to be financially eligible for Medicaid coverage of these services and, where applicable, MLTC enrollment.

22 OHIP/ADM-01 also provides that once the NYIA CSR confirms the individual has active Medicaid, the CSR will schedule both a CHA and a clinical appointment for the individual. The individual will be advised to have relevant medical records available, including a list of current prescriptions. The CSR will offer individuals the option of a telehealth or in-person CHA and clinical appointment. If the individual chooses to have either their assessment or their medical exam performed via telehealth, the CSR will explain the process, ensure that the individual has appropriate equipment and WiFi or Cellular Data to facilitate the evaluations, and make sure that someone can be present to assist the assessor and/or clinician in capturing the necessary information to complete the telehealth appointment.

Under 22 OHIP/ADM-01, the CHA and clinical appointment will be scheduled to be completed within 14 calendar days of contact with the NYIA. If these appointments cannot be completed in this timeframe, the CSR must note the reason in the call record. The individual will receive reminder calls from the NYIA CSR and the Nurse Assessor in advance of the appointments. The LDSS should advise individuals under their care to be on the lookout for calls from unfamiliar phone numbers regarding their assessment; however, the caller ID should read "NY Independent Assessor."

The CHA will assess the individual's need for services, as well as eligibility for MLTC plan enrollment, if applicable. Upon completion of both the CHA and the clinical appointment, the individual will receive a Notice providing direction on next steps, including whether the individual may be eligible for MLTC plan enrollment (in which case they should contact NYIA) and how to contact the LDSS to complete the care planning and service authorization process. All individuals assessed after being referred by the LDSS or approaching the NYIA on their own who are not enrolled in an MMCO will be advised to contact their LDSS or the NYIA for next steps.

22 OHIP/ADM-01 notes that currently, the CHA conducted by the CFEEC is valid for 75 days for the purposes of determining MLTC eligibility. A CHA and PO conducted by the NYIA are valid for 12 months for both PCS/CDPAS service authorization and MLTC eligibility purposes, unless another CHA and PO are required due to a significant change in condition or at the individual's request. LDSS staff may access the CHA and related practitioner order (PO) through the UAS-NY. These documents should be used to develop a Plan of Care (POC) and authorize services.

22 OHIP/ADM-01 provides that during the transition period between the old process and NYIA implementation, a CFEEC CHA conducted after May 16, 2022 will be valid for 12 months for both PCS/CDPAS service authorization and MLTC eligibility purposes, barring a new CHA conducted due to a change in condition, return from institutionalization or at the individual's request. The LDSS is encouraged to use this CFEEC CHA as it would a NYIA CHA for the initial assessment to develop a POC.

Under 22 OHIP/ADM-01, the current practice of initiating PCS and/or CDPAS services with the HCSP-M11Q or the DOH-4359 is discontinued for adults seeking Medicaid State Plan PCS and/or CDPAS on and after May 16, 2022. This third-party physician's order has been used to start the assessment process at the LDSS. The new process is described below.

The revised regulations describe the new medical exam and practitioner order at 18 NYCRR §505.14(b)(2)(ii). 22 OHIP/ADM-01 notes that individuals are determined eligible for PCS and/or CDPAS based on an independent assessment and an order from a qualified, independent clinician who does not have a provider-patient relationship with the individual. The NYIA IPP will conduct the clinical appointment now required to obtain PCS and/or CDPAS and it will occur after the CHA has been conducted.

22 OHIP/ADM-01 provides that the IPP is comprised of qualified, independent clinicians including Medical Doctors (MDs), Doctors of Osteopathy (DOs), Nurse Practitioners (NPs) and Physician or Specialty Assistants (PAs). Any of these practitioners can, as of November 8, 2021, both fill out and sign the Practitioner Order form relied on by the LDSS to authorize PCS and/or CDPAS. The practitioner will conduct the medical exam and complete and sign the Practitioner Order (PO). At the completion of the clinical appointment, the PO will be uploaded to the individual's case record in the UAS-NY.

During the clinical appointment the IPP clinician will:

- review the CHA; examine the individual, either in person or through a telehealth modality; and, if necessary, interview providers and others who may have insight into the individual's needs;

- ensure that the current diagnoses and medications are documented accurately and thoroughly;

- attest to the individual's need for assistance;

- determine whether the individual's medical condition is stable to receive PCS and/or CDPAS;

- indicate whether the individual is self-directing, or has identified an appropriate self-directing other; and

- indicate if they can complete the consumer's roles and responsibilities if they are authorized for and enroll in CDPAS.

22 OHIP/ADM-01 further notes that the PO represents the clinical judgment of the practitioner. They will indicate whether there is a need for services and whether they believe that the individual is medically stable to receive PCS and/or CDPAS. If the IPP clinician determines the individual is not medically stable to receive PCS and/or CDPAS, then the NYIA will send notice to such individuals which will include conference and fair hearing language. The LDSS may not authorize services for individuals that the NYIA IPP has determined are not medically stable to receive PCS and/or CDPAS.

In addition, 22 OHIP/ADM-01 provides that while the NYIA is now responsible for performing the independent CHA and PO, the LDSS remains responsible for developing the individual's plan of care and authorizing PCS and/or CDPAS. In developing the plan of care and authorization of services, the LDSS must review the NYIA CHA and PO and determine that PCS and/or CDPAS are appropriate, medically necessary and can reasonably maintain the individual's health and safety in their home.

22 OHIP/ADM-01 also provides that effective July 1, 2022, the below guidance should be read in conjunction with 16 OHIP/ADM-02, except where 16 OHIP/ADM-02 references the need to perform a social and nursing assessment to determine the need for PCS/CDPAS. Authorization for expedited PCS and/or CDPAS will instead be made based on the LDSS review of the NYIA assessment, conducted as follows.

> If an individual seeks PCS and/or CDPAS based on an immediate need for those services, they may be entitled to expedited Medicaid eligibility and services determinations. To be considered to have an immediate need, the individual must provide the LDSS with an "attestation of immediate need" for PCS and/or CDPAS (Attestation) along with a Practitioner Statement of Need (DOH-5779) from a practitioner who is familiar with the individual's condition. For individuals who are not yet eligible for Medicaid, they must also present a completed Medicaid application.
>
> The previous directive (16 OHIP/ADM-02) required a Physician Order for Immediate Need processing. Because the Physician Order is being replaced with the Practitioner Order, which occurs after the CHA assessment, the Department has replaced the Physician Order with a Practitioner Statement of Need (DOH-5779). In order to streamline the immediate need process, the Practitioner Statement of Need requires less documentation on the part of the practitioner as compared with the Physician Order, and can be completed by a MD, DO, NP or PA. Note, if an individual provides the LDSS with a Physician Order when requesting immediate need processing, the LDSS should accept the Physician Order and not require the Practitioner Statement of Need. Regardless of whether the individual provides a Practitioner Statement of Need or Physician Order to substantiate their immediate need for services, this does not replace the need to obtain an independent Practitioner Order from the IPP.

22 OHIP/ADM-01 further provides that no material changes have been made to the Attestation of Need (OHIP-0103), which has been updated to reflect the new Practitioner Statement of Need (DOH-5779) form. The Attestation form continues to require that the individual attest to the following:

1) their need for assistance,

2) that they have no willing and available informal supports,

3) that they are not currently served by a home care agency,

4) that adaptive or assistive devices are not and cannot meet their needs,

5) they do not have any third-party insurance or Medicare available to pay for needed assistance.

Where Medicaid eligibility for community based long term services has been established the submission of the Practitioner Statement of Need and Attestation of Need forms initiate the start of immediate need processing. Where Medicaid eligibility for community based long term services has not been established, the applicant must also submit a completed Medicaid application to trigger immediate need processing. Please refer to 16 OHIP/ADM-02 for previous guidance on this topic. 22 OHIP/ADM-01

Upon receipt of both the signed Attestation and Practitioner Statement of Need forms, as well as the completed Medicaid application, where applicable, the LDSS must refer adult individuals to the NYIA immediately and without delay. 22 OHIP/ADM-01

22 OHIP/ADM-01 provides that to refer Immediate Need cases to NYIA, the LDSS must use the Expedited/Immediate Need Form. This form should be submitted to NYIA through a dedicated URL. NYIA will outreach to the LDSS to provide them the dedicated URL directly, under separate cover. The LDSS should not submit the "Attestation of Immediate Need" or Practitioner Statement of Need forms to NYIA. The LDSS should also initiate a three-way call with the OSU, the LDSS and the individual. Individuals may not bypass the LDSS when requesting immediate need processing for PCS and/or CDPAS. See 18 NYCRR §505.14(b)(6) and (7) and §505.28(l).

22 OHIP/ADM-01 notes that as indicated in 16 OHIP/ADM-02, an individual with an immediate need for PCS or CDPAS may either be an individual not currently authorized for any type of Medicaid coverage, or a current Medicaid recipient authorized only for community-based coverage that does not include coverage for long-term care services such as PCS or CDPAS. It is the responsibility of the LDSS to, based on a complete Medicaid application, determine the individual's eligibility for Medicaid, including Medicaid coverage of community based long term services. The reasons that an individual may need to be approved under the Immediate Need process have not changed from those in policies and procedures already in effect.

Under the provisions of 22 OHIP/ADM-01, if an individual seeking PCS and/or CDPAS based on an Immediate Need self-refers to the NYIA or is directed to the NYIA by a discharge planner or other referral source, the CSR will direct the individual to call back with a representative of the LDSS. Once Immediate Need is verified through the LDSS by submission of the Expedited/Immediate Need Form, the CSR will schedule a CHA and clinical appointment to be completed within six (6) calendar days. If these appointments cannot be completed in this timeframe, the CSR must note the reason in the call record. All other aspects of the CHA and clinical appointment are the same as the initial assessment process described above.

22 OHIP/ADM-01 provides that the LDSS continues to have no more than 12 calendar days from receipt of the Attestation of Need and Practitioner Statement of Need, and when applicable a completed Medicaid application, to refer the individual to the NYIA for an Immediate Need CHA and clinical appointment, review the outcome, develop a POC and authorize PCS and/or CDPAS as needed. The LDSS shall provide such services to individuals not exempt or excluded from membership in an MMCO until they can be enrolled. The LDSS may not authorize any services unless the individual is determined to be eligible for Medicaid, including coverage of community based long term services. See 18 NYCRR §505.14(b)(4)(i) and 505.28(e)(1)(i).

Section 505.14(a)(4) of the Regulations provides that:

(4) Personal care services, as defined in this section, can be provided only if the services are medically necessary and the social services district reasonably expects that the patient's health and safety in the home can be maintained by the provision of such services, as determined in accordance with the regulations of the Department of Health.

(i) The patient's medical condition shall be stable, which shall be defined as follows:

(a) the condition is not expected to exhibit sudden deterioration or improvement; and

(b) the condition does not require frequent medical or nursing judgment to determine changes in the patient's plan of care; and

(c) (1) the condition is such that a physically disabled individual is in need of routine supportive assistance and does not need skilled professional care in the home; or

(2) the condition is such that a physically disabled or frail elderly individual does not need professional care but does require assistance in the home to

prevent a health or safety crisis from developing.

(ii) The patient shall be self-directing, which shall mean that he/she is capable of making choices about his/her activities of daily living, understanding the impact of the choice and assuming responsibility for the results of the choice. Patients who are non-self-directing, and who require continuous supervision and direction for making choices about activities of daily living shall not receive personal care services, except under the following conditions:

(a) supervision or direction is provided on an interim or part-time basis as part of a plan of care in which the responsibility for making choices about activities of daily living is assumed by a self-directing individual living within the same household; or

(b) supervision or direction is provided on an interim or part-time basis as part of a plan of care in which the responsibility for making choices about activities of daily living is assumed by a self-directing individual not living within the same household...

Administrative Directive 92 ADM-49 provides in pertinent part:

B. Health and Safety of Recipient

Personal care services may only be authorized when the district reasonably expects that the recipient's health and safety can be maintained in the home. This determination must consider the following:

1. Stability of the Recipient's Medical Condition

The assessing nurse has primary responsibility for determining stability of the recipient's medical condition. The recipient and/or any informal caregiver should be given the opportunity to be involved in this determination. The determination should be based on information included in the nursing assessment and a review of the physician's order. In situations where there is a question about this determination, the assessing nurse may wish to involve the case manager or obtain consultation from the local professional director or his/her designee.

A stable medical condition is defined as follows:

a. the condition is not expected to exhibit sudden deterioration or improvement; and

b. the condition does not require frequent medical or nursing judgment to determine changes in the recipient's plan of care; and

c. the condition is such that a physically disabled individual is in need of routine supportive assistance to maintain his or her level of functioning and does not need skilled professional care in the home; or

d. the condition is such that a physically disabled or frail elderly individual does not need professional care but does require assistance in the home to prevent a health or safety crisis from developing.

If the recipient's medical condition is not stable, the provision of personal care services is inappropriate unless a determination is made that the provision of personal care services in combination with the intervention of appropriate skilled nursing services, home health aide and/or therapy can adequately meet the recipient's needs.

The consumer directed personal assistance program is intended to permit chronically ill or physically disabled individuals receiving home care services under the medical assistance program greater flexibility and freedom of choice in obtaining such services.
18 NYCRR 505.28(a).

Section 505.28(b) of Title 18 of the New York Codes, Rules and Regulations provides definitions for the consumer directed personal assistance program.

(2) “consumer” means a medical assistance recipient who a social services district or MMCO has determined eligible to participate in the consumer directed personal assistance program.

(3) “consumer directed personal assistance” means the provision of assistance with personal care services, home health aide services and skilled nursing tasks by a consumer directed personal assistant under the instruction, supervision and direction of a consumer or the consumer’s designated representative.

(4) “consumer directed personal assistant” means an adult who provides consumer directed personal assistance to a consumer under the consumer’s instruction, supervision and direction or under the instruction, supervision and direction of the consumer’s designated representative. A person legally responsible for the consumer’s care and support, a consumer’s spouse, or the consumer’s designated representative may not be the consumer directed personal assistant for that consumer; however, a consumer directed personal assistant may include any other adult relative of the consumer provided that the district or MMCO determines that the services provided by such relative are consistent with the consumer’s plan of care and that the aggregate cost for such services does not

exceed the aggregate costs for equivalent services provided by a non-relative personal assistant.

(5) consumer directed personal assistance program or consumer directed program or the program means the program provided for under section 356-f of title 11 of article 5 of the Social Services Law.

* * *

(7) "designated representative" means an adult to whom a self-directing consumer has delegated authority to instruct, supervise and direct the consumer directed personal assistant and to perform the consumer's responsibilities specified in subdivision (h) of this section and who is willing and able to perform these responsibilities. With respect to a non self-directing consumer, a "designated representative" means the consumer's parent, legal guardian or, subject to the social services district's approval, a responsible adult surrogate who is willing and able to perform such responsibilities on the consumer's behalf. The designated representative may not be the consumer directed personal assistant or a fiscal intermediary employee, representative or affiliated person.

* * *

(15) "personal care services" means the nutritional and environmental support functions, personal care functions, or both such functions, that are specified in Section 505.14(a)(5) of this Part except that, for individuals whose needs are limited to nutritional and environmental support functions, personal care services shall not exceed eight hours per week.

(16) a "self-directing consumer" means a consumer who is capable of making choices regarding the consumer's activities of daily living and the type, quality and management of his or her consumer directed personal assistance; understands the impact of these choices; assumes responsibility for the results of these choices; and is capable of instructing, supervising, managing and directing consumer directed personal assistants and performing all other consumer responsibilities identified in this section.

(17) "skilled nursing tasks" means those skilled nursing tasks that are within the scope of practice of a registered professional nurse or a licensed practical nurse and that a consumer directed personal assistant may perform pursuant to Section 6908 of the Education Law.

Section 505.28(c) of the Regulations outlines the eligibility requirements for individuals to participate in the consumer directed personal assistance program:

(1) be eligible for medical assistance;

(2) be eligible for long term care and services provided by a certified home health agency, or an AIDS home care program authorized pursuant to Article 36 of the Public Health Law; or for personal care services or private duty nursing services;

(3) have a stable medical condition;

(4) be self-directing or, if non self-directing, have a designated representative;

(5) need assistance with one or more personal care services, home health aide services or skilled nursing tasks;

(6) be willing and able to fulfill the consumer's responsibilities specified in subdivision (h) of this section or have a designated representative who is willing and able to fulfill such responsibilities;

(7) participate as needed, or have a designated representative who so participates, in the required assessment and reassessment processes specified in subdivisions (d) and (f) of this section;

Section 505.14(a) of Title 18 of the New York Codes, Rules and Regulations provides definitions and the scope of services of personal care services.

(5) Personal care services shall include the following two levels of care, and be provided in accordance with the following standards:

(i) Level I shall be limited to the performance of nutritional and environmental support functions.

(a) Nutritional and environmental support functions include assistance with the following:

(1) making and changing beds;

(2) dusting and vacuuming the rooms which the patient uses;

(3) light cleaning of the kitchen, bedroom and bathroom;

(4) dishwashing;

(5) listing needed supplies;

(6) shopping for the patient if no other arrangements are possible;

(7) patient's laundering, including necessary ironing and mending;

(8) payment of bills and other essential errands; and

(9) preparing meals, including simple modified diets.

(b) The authorization for Level I services shall not exceed eight hours per week.

(ii) Level II shall include the performance of nutritional and environmental support functions . . . and personal care functions.

(a) Personal care functions include assistance with the following:

(1) bathing of the patient in the bed, the tub or in the shower;

(2) dressing;

(3) grooming, including care of hair, shaving and ordinary care of nails, teeth and mouth;

(4) toileting; this may include assisting the patient on and off the bedpan, commode or toilet;

(5) walking, beyond that provided by durable medical equipment, within the home and outside the home;

(6) transferring from bed to chair or wheelchair;

(7) turning and positioning;

(8) preparing of meals in accordance with modified diets, including low sugar, low fat, low salt and low residue diets;

(9) feeding;

(10) administration of medication by the patient, including prompting the patient as to time, identifying the medication for the patient, bringing the medication and any necessary supplies or equipment to the patient, opening the container for the patient, positioning the patient for medication and administration, disposing of used supplies and materials and storing the medication properly;

(11) providing routine skin care;

(12) using medical supplies and equipment such as walkers and wheelchairs; and

(13) changing of simple dressings.

* * *

(iii) The personal care aide may perform nutritional and environmental support functions and personal care functions for the recipient and may also assist the recipient to perform such tasks themselves. Assistance may include supervision and cueing to help the recipient perform a nutritional and environmental support function or personal care function if the recipient could not perform the task without such assistance. Supervision and cueing are not standalone personal care services and may not be authorized, paid for or reimbursed except for providing assistance with nutritional and environmental support functions or personal care functions.

GIS 13/MA015 provides as follows:

The purpose of this General Information System (GIS) message is to remind local departments of social services (LDSS) of action they should take when a fair hearing decision reverses a LDSS denial of a Medicaid application.

At a fair hearing to review a LDSS denial of a Medicaid application, the Medicaid applicant has the burden of proving that the LDSS's denial was incorrect. When the applicant prevails, the fair hearing decision will reverse the LDSS's denial. The LDSS cannot deny the application based on the reason that was set forth in the agency's denial that was reversed.

When a fair hearing reverses a LDSS denial of a Medicaid application and no remaining eligibility factors need to be considered, the LDSS must find the applicant eligible for Medicaid. The LDSS must find the applicant eligible for Medicaid even if the LDSS requests that the New York State Office of Temporary and Disability Assistance review the fair hearing decision to correct an error of law or fact. The original fair hearing decision is binding and must be complied with pending the review.

When a fair hearing decision reverses a LDSS denial of a Medicaid application and one or more remaining eligibility factors need to be considered, the LDSS must continue to process the application and issue a decision as soon as possible. In such cases, the applicant's original application date must be preserved.

DISCUSSION

By notice dated July 13, 2022, the Agency denied the Appellant's request to enroll in a managed long term care (MLTC) plan. The Agency's determination cannot be sustained on this record.

The Agency representative testified that the Appellant's UAS assessment was conducted on June 14, 2022 in person. At the time of the assessment, the Agency representative stated that the Appellant expressed his goals of care to be "I need help with cleaning and somebody to help with putting lotion and socks on my feet." The Agency representative stated that the Appellant did not have any issues with comprehension or expressing feelings and was easy to converse with. The Agency representative testified that the Appellant was independent with the following tasks:

Meal preparation—performance	Independent
Meal preparation—capacity	Independent
Ordinary housework—performance	Independent
Managing finances—performance	Independent
Managing finance—capacity	Independent
Managing medications—performance	Independent
Managing medications—capacity	Independent
Phone use—performance	Independent
Phone use—capacity	Independent
Bathing	Independent
Personal hygiene	Independent
Dressing upper body	Independent
Dressing lower body	Independent
Walking	Independent
Transfer toilet	Independent
Toilet use	Independent
Bed Mobility	Independent
Eating	Independent

The Agency representative further stated that the Appellant was observed by the nurse assessor to have a slow and unsteady gait, and had difficulty rising from a chair. The Agency representative stated that the Appellant reported that when he would have visitors, he would ask them for as much help as possible while they were there. The Appellant also reported to the nurse assessor that he has extreme pain in his back that radiates down his legs. The Appellant reported that he fell in his apartment about a month prior to the assessment. Based on the foregoing, the Agency representative stated that Appellant was found to have a NFLOC of [redacted], and was determined not to have a need for 120 days continuous services.

The Appellant's representative stated that the Appellant was previously enrolled in an MLTC plan in 2018 and was in receipt of personal care services. The Appellant testified that due to the COVID-19 pandemic, he requested that his personal care services be paused in order to

prevent contracting the virus from aides who were coming in and out of his home. He further stated that he was disenrolled from his plan due to the pause and has been seeking enrollment due to needing assistance with both ADLs and IADLs.

The Appellant's representative introduced a letter dated September 20, 2022 from the Appellant's primary care doctor, which states, in relevant part, that the Appellant suffers chronic medical conditions including but not limited to: [redacted]. The letter further states that the Appellant's condition has [redacted]. The doctor states in her letter that she has [redacted].

The Appellant's representative also stated that there are inconsistencies within the UAS assessment in what the Agency reported. For example, on page two of the assessment it states that the Appellant is reporting an increased need for assistance with ADLS and IADLs, but in the "Functional Status" portion of the assessment, it states that he is independent with most tasks. The Appellant's representative stated that the Appellant's primary doctor also reported that he needs assistance with both ADLs and IADLs.

In response to the Appellant's representative's arguments, the Agency representative stated that the UAS assessment is based on a "three-day look-back." This means that any task that was completed by the Appellant without assistance in the three days prior to the assessment taking place gets marked that the Appellant is independent with the task, regardless of how difficult, insufficient, time consuming, or dangerous the task was for the Appellant. For example, the Appellant being labeled as "Independent" when bathing is because he bathed within the last three days without assistance, even if it was extremely difficult or dangerous for him to do by himself. This standard of review is also exemplified in the nurse assessor's report of the Appellant's functional status which states: "Consumer reports ability to choose clothing and don upper and lower clothing without assist. He does report this takes a long time due to taking many breaks from fatigue and pain. He reports ability to lower and rise from toilet using grab bars and cane, but with difficulty. He reports ability to clean self without assist. Consumer reports ability to move in bed and rise from without assist. But he does report difficulty getting up daily due to pain and decreased mobility." The Appellant is clearly expressing difficulty and pain in completing tasks, but is determined "Independent" with these tasks because they were completed at some point within the last three days, pursuant to the Agency's standard look back period.

The applicable Regulations and policy set forth in the "Applicable Law" section, above, require that, for an individual to be eligible to be enrolled in Managed Long Term Care, the individual must be expected to require at least one of the following services for more than 120 days from the effective date of enrollment:

a. nursing services in the home;
b. therapies in the home;
c. home health aide services;
d. personal care services in the home;
e. adult day health care;
f. private duty nursing; or
g. Consumer Directed Personal Assistance Services (CDPAS)

Review of the June 14, 2022 UAS assessment does reveal numerous inconsistencies. Specifically, the Appellant was stated to live both on the [redacted] floor and the [redacted] floor of an apartment building. The Agency's nurse assessor indicated varying NFLOC scores within the assessment. Most importantly the Agency's nurse assessor indicated that the Appellant had a moderate inability to complete normal daily activities, including ADLs and IADLs, due to diminished energy. Therefore, it was determined that normal day-to-day activities were unable to be finished. The nurse assessor further concluded that the Appellant would benefit from assistance to help him with cleaning, laundry, shopping, bathing, and dressing and qualifies for MLTC of 120 days or greater. However, despite the assessment indicating that the Appellant required such findings in the assessment, it was also stated that the Appellant was not expected to need continued services for a period of 120 days or more. Such contradictions and inconsistencies within the UAS report limit its evidentiary value.

Furthermore, the Agency's UAS assessment conducted on June 14, 2022 establishes that the Appellant requires assistance with Level I personal care services including shopping, housework and transportation. The record further establishes that the Appellant requires assistance with Level II services including bathing and dressing, and that the Appellant's ability to move around has declined, the Appellant requires use of a cane, and the Appellant had fallen within the 90 days prior to the assessment. The Appellant's need for assistance with ADLs and IADLs at home and personal care/CDPAS services is corroborated by his primary care doctor and testimony from the Appellant that he requires this assistance. The Appellant's UAS assessment indicates that the Appellant made complaints of needing assistance with ADL/IADLs due to pain, fatigue, arthritis and decreased mobility. The Appellant not only indicated a need for assistance with cleaning, but with dressing as he needed assistance with putting on socks "because bending over is torture." The UAS assessment reflects that the Appellant currently has no assistance at this time, and that when he has visitors, he asks them for as much help as possible when they are there. The UAS also reflects that for the Appellant to complete certain tasks, it takes a very long time due to their difficulty, his decreased mobility, and needing breaks from fatigue and pain. The Agency representative's argument that the Appellant is marked "Independent" for most tasks because he had completed them within the last three days is unpersuasive. The Appellant currently has no assistance, and therefore must complete tasks on his own, no matter how painful or difficult, or leave them uncompleted.

In fair hearings concerning the denial of an application for, or the adequacy of, Medicaid benefits, including enrollment in MLTC, the Appellant must establish that the denial was not correct or that the Appellant is eligible for a greater amount of assistance or benefits. The Appellant's testimony was consistent and corroborated by his treating physician, making it

credible, thereby meeting this burden. Based on the foregoing, the Agency's determination cannot be sustained and is reversed.

DECISION AND ORDER

The Agency's determination to deny the Appellant's request for enrollment into a managed long term care (MLTC) plan based on the Appellant failing to meet the qualifying criteria, was not correct and is reversed.

1. The Agency is directed find the Appellant eligible for the Managed Long-Term Care Program and notify the Appellant, in writing, of compliance with this Decision.

Should the Agency need additional information from the Appellant in order to comply with the above directives, it is directed to notify the Appellant promptly in writing as to what documentation is needed.

If such information is requested, the Appellant must provide it to the Agency promptly to facilitate such compliance. As required by 18 NYCRR 358-6.4, the Agency must comply immediately with the directives set forth above.

DATED: Albany, New York
11/18/2022

NEW YORK STATE
DEPARTMENT OF HEALTH

By

Heather Clickner

Commissioner's Designee

NEW YORK STATE OF OPPORTUNITY. | Office of Temporary and Disability Assistance

Assistance Information

Important notice enclosed. If you need help reading the notice, call 1-800-342-3334.

Aviso importante adjunto: si necesita ayuda para leer este aviso, marque el 1-800-342-3334.

গুরুত্বপূর্ণ নোটিস সংযুক্ত। আপনার যদি নোটিসটি পড়তে সাহায্যের প্রয়োজন হয়, তাহলে কল করুন 1-800-342-3334 নম্বরে।

إخطار هام مرفق. إذا احتجت إلى المساعدة في قراءة الإخطار يرجى الاتصال بالرقم 1-800-342-3334.

內附重要通告。如需幫助閱讀此通告，請撥打1-800-342-3334。

Un avis important est joint à ce document. Si vous avez besoin d'aide pour la lecture de l'avis, appelez le 1-800-342-3334.

Avi enpòtan enkli. Si w bezwen èd pou w li avi a, rele 1-800-342-3334.

중요한 공지사항이 포함되어 있습니다. 이 공지사항을 읽는데 도움이 필요하시면, 1-800-342-3334로 전화하세요.

Содержит важную информацию. Если при чтении этого извещения у Вас возникнут трудности, позвоните по телефону 1-800-342-3334.

Kèm theo là thông báo quan trọng. Nếu quý vị cần giúp đọc thông báo này, hãy gọi 1-800-342-3334.

ביַיגעלייגט אַ וויכטיקע מעלדונג. אויב איר דאַרפֿט הילף בייַם לייענען די מעלדונג, קלינגט אָן 1-800-342-3334.

Avviso importante incluso. Se ha bisogno di aiuto per leggere l'avviso, contatti il numero 1-800-342-3334.

Ważna informacja w załączeniu. Jeśli potrzebujesz pomocy w przeczytaniu tej informacji, zadzwoń pod numer 1-800-342-3334.

اہم نوٹس منسلک ہے۔ اگر آپ کو نوٹس پڑھنے میں مدد چاہیے تو 1-800-342-3334 پر کال کریں۔